AMENDMENT (08/24/10): ***Page 28, 'District of Columbia Department of Mental Health' has been corrected to state 'District of Columbia Department of Health.'***

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Centers for Disease Control and Prevention (CDC)

Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS

I. AUTHORIZATION AND INTENT

Announcement Type: New - Type 1

Funding Opportunity Number: CDC-RFA-PS10-10181

Catalog of Federal Domestic Assistance Number: 93.523 The Affordable Care Act: Human Immunodeficiency Virus (HIV) Prevention and Public Health Fund Activities

Key Dates:

Application Deadline Date: September 2, 2010, 5:00pm Eastern Standard Time

Authority:
This program is authorized under Sections 317(k)(2) and 318 of the Public Health Service Act (42 U.S.C. Sections 247b(k)(2) and 247c), as amended, and Section 4002 of the Patient Protection and Affordable Care Act (PL 111-148).

Background

The scope of the HIV epidemic in the United States is significant, particularly in large urban areas where cases are concentrated. In 2006, approximately 56,000 new HIV infections occurred in the U.S., demonstrating the need to expand targeted HIV prevention efforts. In addition to broad strategies for the general U.S. population that provide essential knowledge and support an environment conducive to HIV prevention, three targeted strategies are crucial to reducing HIV incidence: 1) increasing knowledge of HIV status among people living with HIV and their partners; 2) reducing risk of HIV transmission from people living with HIV; and 3) reducing HIV acquisition among persons at high risk for infection. Realizing the benefits of these strategies depends on focusing on structural issues (e.g., availability of condoms, sterile syringes, drug treatment, and post-exposure prophylaxis (PEP) and other prevention strategies and interventions), that are known to reduce risk of HIV transmission. These benefits also depend on adequate support for a rigorous, evidence-based approach to HIV prevention that directs resources to the individuals, populations, communities, and activities that will result in the largest reductions in new HIV infections. HIV prevention in the U.S. must be focused and integrated, including an optimal mix of biomedical, behavioral, and structural interventions, adequately funded, and tailored so that levels of services are appropriate to personal and community-level risk of acquiring or transmitting HIV.

At a minimum, all persons should have access to accurate information about HIV transmission and prevention, effective prevention tools (e.g., condoms), and HIV screening. They also should be exposed to social marketing and other communication campaigns that promote HIV awareness and sexual health and encourage involvement in

HIV prevention efforts. In addition, targeted prevention efforts are needed for populations or communities that experience the highest rates of HIV infection and other sexually transmitted diseases. These populations or communities can be defined by geography, race and ethnicity, age, socioeconomic status, gender, gender identity, sexual orientation, or combinations of these factors, and should be consistent with populations identified in the National HIV AIDS Strategy. Intensive prevention interventions and strategies should be directed to these disproportionately affected populations or communities including targeted HIV counseling and testing programs designed to reach persons at high risk for HIV infection, proven biomedical prevention strategies and interventions, and effective community-level and structural HIV prevention efforts.

More intensive prevention efforts are needed for persons at greatest risk of transmitting or acquiring HIV. In addition to individual behavioral factors, risk can be compounded by interpersonal, environmental, and contextual factors -- including substance use, poverty, homelessness, mental illness, concurrent sexually transmitted infections, community incarceration rates, discrimination, sexual and physical abuse, and social and sexual network characteristics. Uninfected persons whose behavior, relationships, or life circumstances put them at high risk of HIV infection, especially those who have partners known to have HIV infection, should be tested for HIV at least once per year; receive intensive evidence-based HIV prevention interventions; and, as needed, be linked to other medical and social services that support reduced HIV acquisition risk (e.g. sexually transmitted disease (STD) screening and treatment, drug treatment, housing, and mental health services). People living with HIV should know their HIV status and be linked to

and maintained in high-quality medical care, including receipt of behavioral interventions to promote successful initiation of, and adherence to, antiretroviral therapy; receive partner services to help notify sex and drug-use partners; be screened for STDs; receive evidence-based behavioral interventions to prevent HIV transmission; and, as needed, be linked to other social services that support the maintenance of reduced transmission risk (e.g., drug treatment, housing, and mental health services). Persons living with HIV who are subsequently diagnosed with an STD or persons named as a partner exposed to HIV or other STD (, should also receive this range of services.

No single intervention is 100% effective, yet in combination they can have a more significant impact on reducing HIV incidence. To harness the full potential of advances in HIV prevention and treatment, jurisdictions with high AIDS prevalence must: 1) enhance HIV prevention planning efforts for maximal effectiveness, (by joint planning of Prevention Planning Groups and Ryan White Care Committees) and 2) coordinate the implementation of and capacity building for delivering strategies and interventions addressing HIV prevention, care, and treatment.

Terminology

For this Funding Opportunity Announcement (FOA), definitions for the following terms apply:

- **Metropolitan Statistical Area (MSA):** MSA are geographic entities defined by the U.S. Office of Management and Budget (OMB) for use by Federal statistical agencies in collecting, tabulating, and publishing Federal statistics. Furthermore,

the underlying concept of an MSA is that of a core area containing a large population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. MSA are composed of entire counties or county equivalents. Every MSA has at least one urbanized area with a population of 50,000 or more.

- **Metropolitan Division:** A metropolitan division (MD) is used to refer to a county or group of counties within a Metropolitan Statistical Area that has a population core of at least 2.5 million. (http://www.whitehouse.gov/omb/assets/bulletins/b10-02.pdf)

Purpose

The purpose of this program is to facilitate the development and implementation of Enhanced Comprehensive HIV Prevention Plans (ECHPPs) for MSAs most affected by the HIV epidemic in order to reduce HIV risk and incidence in those areas. This program will be conducted in two phases. In Phase I, which will be supported under this FOA and will have a one year project period, grantees will develop focused ECHPPs for the targeted MSAs and begin the implementation of those plans. The plans will be guided by the best available evidence and tailored by the jurisdiction with intensive guidance from HHS/CDC. The enhanced plans are intended to identify the optimal combination of coordinated HIV prevention, care, and treatment services that can maximize the impact of these services on reducing new HIV infections within that jursidiction. In Phase II, which will be supported under a separate FOA, a subset of the jurisdictions funded under

Phase I will be selected, through a competitive process, to further implement their Enhanced Comprehensive HIV Prevention Plans over a two year project period.

The ECHPP should serve as a more focused, results-oriented supplement to the jurisdiction's existing Comprehensive HIV Prevention Plan for the purpose of implementing this FOA. The ECHPP should address gaps in scope, reach of HIV prevention interventions and strategies among relevant populations, and coordination of HIV prevention, care and treatment services as it complements, but does not negate, the agreed upon HIV Prevention Comprehensive Plans for community planning under PS10-1001, HIV Prevention Projects. The enhanced plan should strengthen and refocus the jurisdiction's current efforts to significantly reduce the number of new HIV infections and increase access to and use of HIV care and treatment. Additionally, HHS/CDC strongly encourages each grantee to focus the majority of their activities on those priority populations identified in the National HIV/AIDS Strategy with particular emphasis on gay and bisexual men and transgender persons, Black Americans, Latino Americans, and substance users. To a limited extent, and per approval of CDC, additional target populations may be prioritized to the extent this focus is based on the grantee's local epidemiologic profile and epidemic phase and identified in the jurisdiction's Comprehensive HIV Prevention Plan where such focus will have an impact on HIV infection within the jurisdiction. The plan should prioritize programs that are 1) scientifically proven to reduce HIV infection, increase access to care, or reduce HIV-related disparities, 2) able to demonstrate sustained and long lasting (>1 year) outcomes toward achieving any of these goals, 3) scalable to produce desired outcomes at the

community-level, and 4) cost efficient. The goal is for each jurisdiction to create an ECHPP that provides for the improved coordinated implementation of HIV prevention, care, and treatment services using the best mix of interventions, intervention targets, and intervention scale to optimize the impact on new HIV infections.

The enhanced plan should:

1. Review the jurisdiction's current distribution of HIV prevention, care and treatment resources, and evaluate the extent to which these current resources are distributed to maximally reduce HIV incidence. This will include an examination of:
    a. current services (the extent to which persons at greatest risk for acquisition or transmission are being appropriately targeted with a a combination ofservices that are appropriate for that community);
    b. intervention effectiveness (extent to which interventions are evidence-based and effective in reducing HIV at the population-level and
    c. resource distribution (extent to which resource-intensive interventions are targeted for people and communities at highest risk of HIV acquisition or transmission).
2. Address gaps in coverage and/or realign resources to maximally reduce HIV incidence in the jurisdiction. This will include a plan to coordinate services at different points along the continuum of HIV prevention, care and treatment.

Each ECHPP will include a mixture of interventions and public health strategies selected by that jurisdiction from three categories: a) required; b) recommended for consideration; and c) innovative local activities. Innovative local activities must be approved by CDC

for inclusion in the enhanced plan. Interventions and strategies in the "required" and "recommended for consideration" categories are described below. If opportunities for program improvement through the use of CDC-endorsed and supported new or emerging interventions or strategies are identified, grantees will have the opportunity to modify their programmatic activities accordingly during the project period. If the grantee or jursidiction is already funding a required intervention or strategy at sufficient scale, and it is well coordinated with other HIV prevention, care, and treatment activities, then the grantee is not required to spend additional funds from this announcement for that intervention or strategy. Grantees should maintain funding for all interventions that are well cooridnated and focsued on high-risk populations. Funding should not be diverted from these priority activities. Grantees should coordinate and collaborate with their appropriate local health departments, local community planning groups, community based organizations (CBOs), other local HIV planning bodies, mental health and substance abuse services, local communities, and other appropriate governmental and non-governmental entities in the implementation of this FOA's activities.

Grantees are also expected to begin implementing required interventions and strategies from their plan within the one year project period of Phase I. It is anticipated that additional competitive funding may be available for Phase II as increased funds were requested in the FY 2011 President’s Budget (depending on the availability of appropriations), during which the enhanced plan will be fully implemented over an additional 2-year project period. Funding through this FOA is not available for Phase II activities.

Interventions and strategies that are **required** to be included in the ECHPP and implemented during the project period include the following:

- Routine, opt-out screening for HIV in clinical settings of patients ages 13-64 (Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm?s_cid).
- HIV testing in non-clinical settings to identify undiagnosed HIV infection (Revised Guidelines for HIV Counseling, Testing, and Referral, 2001. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm) including using strategies such as social network recruitment.
- Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection.
- Provision of Post-Exposure Prophylaxis to populations at greatest risk. (Smith DK, Grohskopf LA, Black RJ, et al. Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. *MMWR*. 2005; 54:1-20. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm).
- Where applicable, and subject to lobbying restrictions under federal law (see Administrative and National Policy Requirements, AR-12, Lobbying Restrictions, below), efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment (e.g., address availability of condoms, sterile syringes, drug treatment, and post-exposure

prophylaxis (PEP) and other prevention strategies and interventions; address barriers to CDCs 2006 HIV testing recommendations or to CD4 and viral load (VL) reporting; examine the feasibility of providing anti-retroviral treatment (ART) for all HIV-positive persons; examine potential opportunities for using laboratory data for improving patient prevention, care, and treatment; address regulations against pharmacy sale of sterile syringes). (Also, see http://www.cdc.gov/HIV/resources/guidelines/PDF/SSP-guidanceacc.pdf for a description of use of federal funds for syringe services programs).

- In accordance with guidelines, (Incorporating HIV Prevention into the Medical Care of Persons Living with HIV. Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America, 2003. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm), implement the following for HIV-positive persons:
  - Linkage to HIV care, treatment, and prevention services for those testing positive and not currently in care;
  - Interventions or strategies promoting retention in or re-engagement in care;
  - Policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines (Panel on Antiretroviral Guidelines for Adults and Adolescents: Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents, 2009. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf);
  - Interventions or strategies promoting adherence to antiretroviral medications;

- STD screening according to current guidelines (STD Treatment Guidelines, 2006. Available at http://www.cdc.gov/std/treatment);
- Prevention of perinatal transmission (Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States, 2010. Available at http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf);
- Ongoing partner services (Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection, 2008. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm);
- Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV (see www.effectiveinterventions.org or http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm);
- Linkage to other medical and social services (e.g., mental health treatment, drug treatment, housing assistance).

Interventions and strategies that are **recommended for consideration** for inclusion in the ECHPP include the following:

- Condom distribution for the general population.
- HIV and sexual health communication or social marketing campaigns targeted to relevant audiences (e.g., providers ["Prevention is Care" http://www.cdc.gov/hiv/topics/treatment/PIC/; and "HIV Screening. Standard Care"

http://www.cdc.gov/hiv/topics/treatment/PIC/], high risk populations or communities, or the general population).

- Clinic-wide or provider-delivered evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV (see www.effectiveinterventions.org or http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm).
- Community interventions that reduce HIV risk (see www.effectiveinterventions.org).
- Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship (see www.effectiveinterventions.org or http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm).
- Integrated hepatitis, TB, and STD testing, partner services, vaccination, and treatment for HIV infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines.
- Targeted use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis, and persons with a previous STD diagnosis who receive a new STD diagnosis.
- For HIV-negative persons at highest risk of acquiring HIV, broadened linkages to and provision of services for social factors impacting HIV incidence such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others.

- Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV.
- Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors.

Evaluation: For implementation of any new or expanded interventions or public health strategies as part of this funding announcement, grantees should collect monitoring and evaluation data regarding prevention activities conducted as part of this announcement, consistent with current CDC data requirements for data reporting related to programmatic activities. It is expected that grantees will actively monitor local program performance and use this information on a regular basis to evaluate and improve program implementation, outcomes, and impact.

Additional evaluation of grantees' overall programmatic implementation of the ECHPP will be conducted separately by CDC. This additional evaluation is relevant for Phases I and II of the program and will examine data from before and after implementation and assess grantees achievement of program implementation, outcome and impact goals. During Phase I, CDC will identify specific indicators of program implementation, outcome, and impact that will be used to assess grantee performance in Phase II. These indicators may include, but are not limited to:

1) Implementation indicators such as number of people tested, number of people newly diagnosed with HIV, number of condoms distributed, and number of persons receiving specific prevention services (e.g., partner services, prevention with positive interventions, PEP, syringe service programs);
2) Outcome measures focused on number of newly diagnosed people linked to clinical care within 3 months of diagnosis, early HIV diagnosis, integration of HIV prevention into medical care of people living with HIV, HIV viral load (particularly among MSM, Blacks, and Latinos), exposure to HIV prevention programs and services, and sexual and injection risk behaviors;
3) Impact indicators (from existing CDC surveillance systems) such as HIV prevalence and number of new HIV diagnoses;
4) Indicators of changes in organizational practices, regulations, and policies that impact the public health practice of combination HIV prevention including proven biomedical, behavioral, and structural strategies and interventions. More details about the related evaluation activity will be provided at the first grantee meeting in October 2010.

Program Collaboration and Service Integration (PCSI): This program supports the National Center for HIV, Viral Hepatitis, STD, & TB Prevention (NCHHSTP) program imperative calling for program collaboration and service integration (PCSI). The rationale for PCSI is to maximize the health benefits that persons receive from prevention services by increasing service efficiency; maximizing opportunities to screen, test, treat, or vaccinate those in need of these services; improving the health among populations

negatively affected by multiple diseases; improving operations through the use of shared data; and enabling service providers to adapt to, and keep pace with, changes in disease epidemiology and new technologies.

This announcement encourages and supports integration of diagnostic and prevention services for the Human Immunodeficiency Virus (HIV), hepatitis C virus (HCV), hepatitis B virus (HBV), sexually transmitted diseases (STD); and tuberculosis (TB) because of CDC's greater understanding of the extent to which:

- STDs increase the risk for HIV infection.
- Control of TB, viral hepatitis, and STDs is needed to protect the health of HIV-infected persons.
- HIV, viral hepatitis and STDs share common risks and modes of transmission.
- Risks for acquiring theses diseases are associated with similar behaviors and environmental conditions and have reciprocal or interdependent effects.
- Clinical course and outcomes of these diseases are influenced by co-infection (for example, HIV/TB can be deadly, and TB accelerates HIV disease progression).
- Populations disproportionately affected by HIV are also disproportionately affected by infections with TB, HCV, HBV, and STDs.

Details of this strategy and approach are outlined in the NCHHSTP White Paper which can be found at http://www.cdc.gov/nchhstp/programintegration .

Reduce Health Disparities and Address Social Determinants of Health:

The program supports efforts to improve the health of populations disproportionately affected by HIV/AIDS, viral hepatitis, STDs and TB by maximizing the health impact of public health services, reducing disease prevalence , and promoting health equity consistent with the National HIV/AIDS Strategy available at http://www.whitehouse.gov/administration/eop/onap/nhas.

Health disparity is a particular type of health difference that is closely linked with social or economic disadvantage based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion.

[HP 2020 - http://healthypeople.gov/hp2020/advisory/PhaseI/glossary.htm]. Health disparities in HIV, viral Hepatitis, STDs, and TB are inextricably linked to a complex blend of social determinants that influence which populations are most severaly affected by these diseases.

Social determinants are the economic and social conditionis that influence the health of individuals, communities and jurisdictions and include conditions for early childhood development: education, employment, and work; food security, health services, housing, income and social exclusion.

Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. It requires:

- Continuous efforts focused on eliminnation of health disparities, including disparities in health and in the living and working conditions that influence health, and
- Continuous efforts to maintain a desired statte of equity after particular health disparities are eliminated.

Programs should use data, including social determinants data, to identify communities within their jurisdiction that are disporportionately affected by HIV, Viral Hepatitis, STDs and TB and related diseases and conditions, and plan activities to help eliminate health disparities. In collaboration with partners and appropriate sectors of the community, programs should consider social determinants of health in the development, implementation, and evaluation of program specific efforts and use culturally appropriate interventions that are tailored for the communities for which they are intended.

Healthy People 2010: This program addresses the "Healthy People 2010" focus area(s) of HIV prevention.

Measurable Outcomes: Measurable outcomes of the program will be in alignment with one (or more) of the following performance goal(s) for the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP):

- Decrease the number of persons at high risk for acquiring or transmitting HIV infection.

- Strengthen the capacity nationwide to monitor the epidemic; develop and implement effective HIV prevention interventions; and evaluate prevention programs.

Non-Research Activities: This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address: http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm

II. PROGRAM IMPLEMENTATION

Recipient Activities:

Planning Process

Recipients (grantees) should engage in an orderly planning process as described:

- Identify, engage, and coordinate planning with key stakeholders and partners, including but not limited to local planning groups, community-based organizations that have a proven track record for success in their efforts to appropriately scale up available HIV prevention interventions and strategies, care providers from the public and private sector, community health centers, mental health and substance abuse services, local communities, and other appropriate governmental and non-governmental entities.
- For state health departments funded through this announcement: partner with and substantially involve local public health staff, service providers, and community representatives in the MSA or Metropolitan Division with the highest AIDS prevalence in the state health department's jurisdiction (not including MSAs or

Metropolitan Divisions in directly funded city health department jurisdictions), as defined in the FOA.

- Identify HIV prevention interventions and strategies for implementation that address gaps in the scope, reach or coordination of evidence-based interventions and public health strategies for the continuum of HIV prevention, care, and treatment as defined in the FOA. The ECHPP should constitute an optimal portfolio of interventions and strategies that is feasible, results oriented, and consistent with the National HIV/AIDS Strategy. When determining the optimal portfolio of interventions or strategies, grantees should;
  - Develop a logic model that indicates how those interventions/strategies are expected to work together at an individual and community level and should consider the cost-effectiveness of interventions and public health strategies if these data are available.
  - Ensure that existing prevention and care resources are allocated based upon the local HIV epidemiological profile to achieve and support more equitable resource distribution and make the greatest impact on the HIV epidemic.
  - Identify ways to expand implementation of proven biomedical interventions that prevent HIV transmission or acquisition, leverage other local resources to make proven biomedical interventions more widely available, and plan to use CDC resources to implement proven biomedical, behavioral and structural interventions (including PEP).

Review of Relevant Information

Grantees should review relevant information as described:

- Review the existing Comprehensive HIV Prevention Plan
- Examine the jurisdiction's current Community Services Assessment and conduct additional assessments as necessary to identify opportunities for selection, adjustment, and coordination of interventions and strategies across funding streams to optimize the impact of HIV prevention, care, and treatment. State grantees will focus their assessment (if the relevant jurisdiction does not have a current Community Services Assessment) or additional assessment (if the relevant jurisdiction does have a current Community Services Assessment) on the MSAs or specified Metropolitan Divisions within MSAs that have high AIDS prevalence, as listed in the FOA.
- Examine current spending patterns in the jurisdiction and the degree to which resource allocations align with the local HIV epidemiological profile.
- Review the most recent assessment of current capacity and capacity building needs for delivering strategies and interventions in the targeted MSA. If the grantee's most recent assessment does not include the capacity building needs of the targeted MSA, a capacity building needs assessment specific to the requirements of this FOA should be undertaken. Findings from this assessment should be addressed in the enhanced plan to the extent that addressing the findings will improve program results and help to reduce HIV incidence.

Planning Output

The output of the planning process should be an Enhanced Comprehensive HIV Prevention Plan:

- By January 15, 2011, draft a written plan that can be shared with CDC and stakeholders and discussed at the January grantee meeting described below. The final written plan should be submitted by January 31, 2011. The plan should follow a template that will be finalized at the first project meeting after discussions between CDC and the grantees. The plan will include, but not be limited to, the following:
    a. An assessment of the reach and effectiveness of HIV prevention interventions and strategies among relevant populations as well as resources invested in current activities;
    b. Reach and gaps for effective interventions among relevant populations and opportunities to target intervention types and levels provided to relevant populations;
    c. Priority activities for which additional resources could augment the impact of existing resources by filling program gaps, improving infrastructure (systems, data, human), and supporting capacity building and technical assistance (TA) activities;
    d. The extent to which structures, regulations, and policies impede implementation of effective prevention strategies and, subject to lobbying restrictions under federal law (see Administrative and National Policy Requirements, AR-12, Lobbying Restrictions, below) opportunities to remove such barriers;

e. Mechanisms for Program Collaboration Service Integration (PCSI) at different points along the continuum of prevention, care, and treatment;

f. A review of how implementation of the plan will help to reduce new HIV infections; and

g. A timeline indicating when each proposed activity would be initiated and at full operation.

Implementation and Evaluation

- Begin, continue, or scale up implementation of the required interventions and strategies in the ECHPP. Certain aspects of the implementation should be feasible before the plan is finished and, in consultation with CDC, will be encouraged.
- Assure reporting of diagnoses of HIV infection as well as reporting of all required HIV related testing information (including CD4 and viral load tests) to state and local HIV surveillance programs
- For all new or expanded implementation of interventions or public health strategies as part of this funding announcement, grantees should collect monitoring and evaluation data consistent with current CDC data requirements for data reporting related to programmatic activities. This would include any additional program evaluation planning and staffing in order to conduct required data collection and submission activities, utilize program and other data for local program improvement, and submit required data to CDC via CDC-approved data systems and according to a CDC prescribed reporting schedule. All HIV testing data should be submitted (either via key entry or in uploaded in XML format) to the new HIV testing data system.

- Collaborate with the evaluation team identified by CDC and tasked with additional evaluation of grantees' overall programmatic implementation of the ECHPP.
- Evidence that a data-driven and inclusive (of communities affected and a broad partnership base) process has been used to assess health disparities related to HIV, Viral Hepatitis, STDs and TB within the jurisdiction.
- Evidence that culturally appropriate interventions, including structural interventions and policies, tailored for disproportionately affected communities have been developed, implemented, and evaluated in collaboration with a diverse group of partners.
- Evidence of the development of strategic alliances with other partners and sectors to address social determinants of health to reduce health disparities as well as to reduce service redundancies and provision of non-essential services.

Personnel

- Have two or three key staff attend quarterly meetings convened by CDC with all grantees. At least two meetings will be in Atlanta; grantees should budget for key staff to attend all meetings. The first meeting will be held in Atlanta in October 2010 and the second meeting will be held in mid-January, 2011.
- Ensure that staff has adequate training to implement all interventions and strategies included in the grantee's ECHPP.

HHS/CDC Activities:

In a cooperative agreement, HHS/CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring. HHS/CDC activities for this program are as follows:

1. Provide consultation and technical assistance to grantees on all aspects of the development and finalization of the ECHPP as well as all protocols, procedures, and instruments related to the plan, both directly and through CDC's network of grantees and partners.
2. Provide each grantee with a team of CDC scientists and program staff who will provide specific TA for development of the ECHPP.
3. Provide a template for the plan no later than the date of the first grantee meeting.
4. Work with grantees to identify and address training and technical assistance needs that are crucial to the successful development and execution of the plan, and that are not currently addressed by other funding sources.
5. Disseminate current information, including best practices, on all intervention and public health strategies to prevent HIV infection, and facilitate the inclusion of effective intervention models in the plan.
6. Work with HRSA, CMS and other payers to increase access to proven biomedical interventions, including care and treatment for persons diagnosed with HIV, at the national and local levels.
7. Facilitate coordination, collaboration, and where feasible, service integration among other CDC programs, health departments and their programmatic divisions, local planning groups, directly-funded CBOs, national capacity building assistance providers, care providers and other recipients of Ryan White Treatment Extension

Act of 2009, and other critical partners working with at risk populations and towards common goals of risk reduction, disease detection, and a continuum of HIV prevention, care, and treatment.

8. Monitor grantee progress in developing and implementing the ECHPP, and work with grantees through consultation via site visits, email, telephone, and review of progress reports to support development and implementation of the enhanced plan.
9. Monitor grantee progress in developing monitoring and evaluation plans and work with grantees through consultation via site visits, email, telephone, and review of progress reports and other data reports to support progress, program improvement, and reduced HIV transmission.
10. Provide requirements and expectations for standardized and other data reporting and support monitoring and evaluation (M&E) activities with contractual technical assistance, web-based training on M&E, M&E-related materials such as data collection tools, and on-line TA via the NHM&E Service Center.
11. Obtain necessary CDC and other clearances.
12. Convene, plan, and facilitate quarterly joint grantee meetings during the project period.

III. AWARD INFORMATION AND REQUIREMENTS

Type of Award: Cooperative Agreement. CDC's substantial involvement in this program appears in the Activities Section above.

Award Mechanism: U65 HIV Prevention Activities

Fiscal Year Funds: 2010

Approximate Current Fiscal Year Funding: up to $12,000,000

Approximate Total Project Period Funding: up to $12,000,000 (This amount is an estimate, and is subject to availability of funds. This amount is includes both direct and indirect costs.)

Approximate Number of Awards: 12

Approximate Average Award: $1,000,000 (This amount is for the 12 month budget period, and includes both direct and indirect costs.)

Floor of Individual Award Range: $750,000

Ceiling of Individual Award Range: $1,750,000 (This ceiling is for the 12 month budget period, and includes both direct and indirect costs.) CDC will accept and review applications with budgets greater than the ceiling amount.

Anticipated Award Date: September 30, 2010

Budget Period Length: 12 Months

Project Period Length: 1 Year

Funding Formula: In determining the final funding formula for awards, CDC will provide all grantees with a base funding amount of $750,000 and include additional tiered funding based on the number of people living with AIDS, year-end 2007. All funding is subject to the availability of federal funds.

***AIDS Prevalence Tiers**	**Additional Funding Range**
Tier 1 = 24,000 - 70,000 cases	$300,000 - $1,200,000
Tier 2 = 12,000 - 23,999 cases	$200,000 - $600,000
Tier 3 = 7,000 - 11,999 cases	$100,000 - $300,000

The table below is the estimated prevalence for persons living with AIDS, year end 2007 by top MSAs and MDs – United States and Puerto Rico (from Table 24. *2008 HIV*

Surveillance Report)

http://www.cdc.gov/hiv/surveillance/resources/reports/2008report/index.htm .

2007 Rank	MSA/MD	2007 Estimated AIDS Prevalence
1	New York Division	66,426
2	Los Angeles Division	24,727
3	Washington Division	15,696
4	Chicago Division	14,175
5	Atlanta-Sandy Springs-Marietta, GA	13,105
6	Miami Division	12,732
7	Philadelphia Division	12,469
8	Houston-Baytown-Sugar Land, TX	11,277
9	San Francisco Division	11,026
10	Baltimore-Towson, MD	10,301
11	Dallas Division	7,993
12	San Juan-Caguas-Guaynabo, PR	7,858

IV. ELIGIBILITY

Eligible Applicants

Eligible applicants that can apply for this funding opportunity are listed below:

- State and local governments or their Bona Fide Agents as specified in the Eligible Jurisdictions (below).

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a Bona Fide Agent of an eligible state or local government, a Memorandum of Agreement with the eligible state or local government as documentation of the status is required and

must be submitted with the application. At a minimum, the Memorandum of Agreement must include the following:

- Roles and responsibilities of the state or local government agency.
- Roles and responsibilities of the Bona Fide Agent.
- Key personnel contacts for the state or local government agency.
- Key personnel contacts for the Bona Fide Agent.

Attach the Memorandum of Agreement with "Other Attachment Forms" when submitting via www.grants.gov .

Eligible Jurisdictions

Applicants eligible to apply for this cooperative agreement are limited to twelve (12) entities in specific Metropolitan Statistical Areas (MSAs) or specified Metropolitan Divisions (MDs) that have the highest estimated AIDS prevalence at the end of 2007. These twelve eligible areas comprise 44% of the total estimated persons living with AIDS in the United States as of the end of 2007.

The entities eligible to apply for funds under this FOA are as follows:

	Eligible Applicant	**Corresponding MSA/MD**
1.	New York City Department of Health and Mental Hygiene	New York Division
2.	Los Angeles County Public Health Department	Los Angeles Division
3.	District of Columbia Department of ~~Mental~~ Health	Washington Division
4.	Chicago Department of Public Health	Chicago Division
5.	Georgia Department of Human Resources	Atlanta-Sandy Springs-Marietta, GA

6.	Florida State Department of Health	Miami Division
7.	City of Philadelphia Public Health Department	Philadelphia Division
8.	Houston Department of Health and Human Services	Houston-Baytown-Sugar Land, TX
9.	San Francisco Department of Public Health	San Francisco Division
10.	Maryland State Department of Health	Baltimore-Towson, MD
11.	Texas State Department of Health Services	Dallas Division
12.	Puerto Rico Department of Health	San Juan-Caguas-Guaynabo, PR

The MSA or MD with the highest AIDS prevalence in the state health department jurisdiction was selected for eligibility, not accounting for MSAs or MDs in directly funded city health department jurisdictions. Projects will be supported only within the MSA or MD listed and only within the geographic bounds of the funded entity (where MSAs/MDs extend beyond the jurisdiction of the eligible state or city health department). Activities may be limited to the geographic area (e.g., city, county, or health district) within the MSA or MD with the highest AIDS morbidity where it would be impractical to conduct activities in the entire area. Activities may be extended to geographic areas adjacent to the MSA or MD where AIDS morbidity remains high. Either limiting or extending the geographic area for project activities is contingent upon prior CDC approval.

Cost Sharing or Matching:

Cost sharing or matching funds are not required for this program.

Maintenance of Effort

Maintenance of Effort is not required for this program.

Other

If a funding amount greater than the ceiling of the award range is requested, the application will be considered non-responsive and will not be entered into the review process. The applicant will be notified that the application did not meet the submission requirements.

The successful applicant may be responsible for planning, implementing, and coordinating infrastructure development requirements supporting the primary public health purpose of this FOA.

Special Requirements:

If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified the application did not meet submission requirements.

- Late applications will be considered non-responsive. See section "IV.3. Submission Dates and Times" for more information on deadlines.
- Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting a grant, loan, or an award.

V. APPLICATION AND SUBMISSION INFORMATION

Address to Request Application Package

To apply for this funding opportunity use the application forms package posted in Grants.gov.

APPLICATION CONTENT

CDC Assurances and Certifications can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm

Project Abstract

A Project Abstract must be completed in the Grants.gov application forms. All electronic project abstracts must be uploaded in a PDF file format when submitting via Grants.gov. The abstract must be submitted in the following format:

- Maximum of 2-3 paragraphs;
- Single-spaced

The Project Abstract must contain a summary of the proposed activity suitable for dissemination to the public. Do not copy & paste text into the Project Abstract Form as it may cause electronic submission errors due to unacceptable characters. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

Project Narrative

A project narrative must be submitted with the application forms. All electronic narratives must be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages: **15**. If the applicant's narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed;
- Font size: 12 point, unreduced, Times New Roman;
- Double spaced;
- Paper size: 8.5 by 11 inches (preferred), or generally accepted paper size;
- Page margin size: One inch;
- Number all document pages of the application (excluding the forms provided in the application package) sequentially from page one (Application Face Page) to the end of the application, including charts, figures, tables, and appendices; and

The narrative should address activities to be conducted over the entire project period and must include the following items in the order listed:

A. Planning Process

- Identify key stakeholders, partners, community-based organizations, and local planning groups that should be included in the development of the plan.
- <u>For state health departments funded through this announcement</u>: propose to partner with and substantially involve local public health staff, service providers, and community representatives in the MSA or Metropolitan Division with the

highest AIDS prevalence in the state health department's jurisdiction (not including MSAs or Metropolitan Divisions in directly funded city health department jurisdictions), as defined in the FOA.

- Describe a method for engaging these collaborators that will allow for their active, meaningful participation throughout the planning process.
- Determine a process for developing a logic model and identifying an optimal portfolio of interventions and strategies that is feasible and results oriented and will address gaps in the scope, reach or coordination of for the continuum of HIV prevention, care, and treatment as defined in the FOA.

B. Review of Relevant Information

- Identify a process to review the existing Comprehensive HIV Prevention Plan, examine the jurisdiction's current Community Services Assessment and conduct additional assessments as necessary to identify opportunities for selection, adjustment, and coordination of interventions and strategies across funding streams to optimize the impact of HIV prevention, care, and treatment.
- State health departments identify a process to focus their assessment (if the relevant jurisdiction does not have a current Community Services Assessment) or additional assessment (if the relevant jurisdiction does have a current Community Services Assessment) on the MSAs or specified Metropolitan Divisions within MSAs that have high AIDS prevalence, as listed in the FOA.

- Identify a process to review examine current spending patterns in the jurisdiction and the degree to which resource allocations align with the local HIV epidemiological profile.
- Identify a process to review the most recent assessment of current capacity and capacity building needs of the targeted MSA or to undertake a new assessment if a relevant assessment specific to the targeted MSA does not exist.

C. Planning Output

- Propose a planning process with clear, specific steps and a timeline that will result in the development of a draft ECHPP by January 15, 2011, that can be shared with HHS/CDC and stakeholders and discussed at the January grantee and a final written plan will be submitted by January 31, 2011.

D. Implementation and Evaluation

- Propose to begin, continue, or scale up implementation of the required interventions and strategies in the ECHPP during the project period.
- Assure reporting of diagnoses of HIV infection as well as reporting of all required HIV related testing information (including CD4 and viral load tests) to state and local HIV surveillance programs.
- Agree to collect monitoring and evaluation data consistent with current CDC data requirements for data reporting related to programmatic activities for all new or expanded implementation of interventions or public health strategies as part of this funding announcement.

- Agree to collaborate with the evaluation team identified by CDC and tasked with additional evaluation of grantees' overall programmatic implementation of the ECHPP.

E. Personnel

- Include a staffing plan that is appropriate and sufficient to accomplish the program goals and clearly defines staff roles.
- Agree to send two or three key staff to attend quarterly meetings convened by CDC with all grantees, including the meeting to be held in Atlanta in October 2010.

a. Ensure that staff has adequate training to implement all interventions and strategies included in the grantee's ECHPP.

F. Budget

The budget justification **will not be counted** in the stated page limit. In accordance with Form CDC 0.1246E (*www.cdc.gov/od/pgo/forms/01246.pdf*), applicants are required to provide a line item budget and narrative justification for all requested costs that are consistent with the purpose, objectives, and proposed program activities. The budget and budget justification should be placed in the application's attachments and named as *Budget and Budget Justification.*

Within the budget, include the following:

1. A detailed, line-item budget and justification (also known as a "budget narrative").

2. A line-item breakdown and justification for all personnel; that is name, position title, actual annual salary, percentage of time and effort, and amount requested).
3. A line-item breakdown and justification for all contracts, including:
    a. Name of contractor and/or consultants.
    b. Applicant affiliation (if applicable).
    c. Nature of services to be rendered.
    d. Relevance of service to the project or justification for use of a consultant.
    e. Period of performance (dates) or number of days of consultation (basis for fees).
    f. Method of selection (for example, competitive or sole source).
    g. Description of activities.
    h. Target population.
    i. Itemized budget and expected rate of compensation (for example, travel, per diem, and other related expenses); list a subtotal for each consultant in this category.
        1) If the above information is unknown for any contractor/consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget if the applicant is selected for funding.
4. Justification for any requests for Direct Assistance.
5. Funds must be included for two to three persons to attend quarterly meetings convened by CDC with all grantees.

NOTE: Applications should be shared with the Co-Chairs of the jurisdiction's HIV prevention community planning group(s). During the funding year, jurisdictions will

develop Enhanced Comprehensive HIV Prevention Plans that are aligned with the three categories of activities identified in this FOA. Grantees are strongly encouraged to engage their local planning groups as they develop the plan, and to expand the composition of the planning groups to more fully incorporate the knowledge, skills and expertise needed to inform the implementation of the required activities in this FOA. Additionally, where appropriate, HHS/CDC strongly encourages each grantee to focus activities on those priority populations identified in the jurisdiction's comprehensive HIV prevention plan and to consider focusing on emerging populations or communities where such focus will have an impact on HIV infection within the jurisdiction. The plan that is developed is intended to supplement and complement the activities outlined within the grantee's current Comprehensive HIV Prevention Plan.

Additional Information:

Additional information submitted via Grants.gov should limited to no more than 50 pages should be uploaded per application. Files should be uploaded in a PDF file format, and should be named using the following format, "*OtherNarrativeAttachments Attachment X [Name of Item].pdf*". For example:

- OtherNarrativeAttachments Attachment I Organizational chart.pdf
- OtherNarrativeAttachments Attachment II Resumes.pdf
- OtherNarrativeAttachments Attachment III Letters of support.pdf

Other Submission Requirements

A letter of intent is not applicable to this funding opportunity announcement.

APPLICATION SUBMISSION

Registering any organization through www.Grants.gov, the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located on the "Get Registered" screen of www.Grants.gov. Please visit www.Grants.gov at least 30 days prior to submitting an application to become familiar with the registration and submission processes. The "one-time" registration process will take three to five days to complete. However, the Grants.gov registration process also requires the applicants register their organization with the Central Contractor Registry (CCR) annually. The CCR registration can require an additional one to two days to complete.

Submit the application electronically by using the forms and instructions posted for this funding opportunity on. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO TIMS) staff at (770) 488-2700 for further instruction.

Note: Application submission is not concluded until successful completion of the validation process.

After submission of an application package, applicants will receive a "submission receipt" email generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged check the status of their application to ensure submission of their application package is complete and no submission errors exists. To guarantee an applicant complies with the application deadline published in the Funding Opportunity Announcement, applicants are also strongly encouraged to allocate additional days

prior to the published deadline to file their application. Non-validated applications will not be accepted after the published application deadline date.

In the event an applicant does not receive a "validation" email within <u>two (2) business days</u> of application submission, the applicant should contact Grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0 page 57.

Dun and Bradstreet Universal Number (DUNS)

The applicant is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) identifier to apply for grants or cooperative agreements from the Federal government. The DUNS is a nine-digit number which uniquely identifies business entities. There is no charge associated with obtaining a DUNS number. Applicants may obtain a DUNS number by accessing the Dun and Bradstreet website or by calling 1-866-705-5711.

Electronic Submission of Application:

Applications must be submitted electronically at www.Grants.gov. The application package can be downloaded from www.Grants.gov. Applicants can complete the application package off-line, and then upload and submit the application via the Grants.gov Web site. The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (http://www.grants.gov), are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when Grants.gov receives the application. The tracking number serves to

document submission and initiate the electronic validation process before the application is made available to CDC for processing.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. Applicants can reach the Grants.gov Support Center at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

Organizations that encounter technical difficulties in using www.Grants.gov to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, support@grants.gov). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to the Grants Management Specialist (found in Section VIII, "Agency Contacts") for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevent electronic submission and the efforts taken with the Grants.gov Support Center (c) be submitted to the Grants Management Specialist & PGO TIMS (found in Section

VIII, "Agency Contacts") at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

Submission Dates and Times

This announcement is the definitive guide on application content, submission, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review and the applicant will be notified the application did not meet the submission requirements.

Application Deadline Date: September 2, 2010, 5:00pm Eastern Standard Time.

VI. APPLICATION REVIEW INFORMATION

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the Cooperative Agreement. Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures must be objective and quantitative and must measure the intended outcome. The measures of effectiveness must be submitted with the application and will be an element of evaluation.

EVALUATION CRITERIA

Eligible applications will not receive a numeric score, but instead will receive a Technical Review to evaluate their technical acceptability. All technically acceptable applications will be funded for a period of one (1) year. Applications will be reviewed against the following criteria:

A. Planning Process

- Has the applicant identified key stakeholders, partners, community-based organizations, and local planning groups that should be included in the development of the plan?
- For state health departments funded through this announcement: Has the applicant proposed to partner with and substantially involve local public health staff, service providers, and community representatives in the MSA or Metropolitan Division with the highest AIDS prevalence in the state health department's jurisdiction (not including MSAs or Metropolitan Divisions in directly funded city health department jurisdictions), as defined in the FOA?
- Does the applicant describe a method for engaging these collaborators that will allow for their active, meaningful participation throughout the planning process?
- Does the applicant appropriately address the high priority populations as defined by prevalence data for their specific area?
- Has the applicant determined a process to develop a logic model and for identifying an optimal portfolio of interventions and strategies that is feasible and

results oriented and will address gaps in the scope, reach or coordination of for the continuum of HIV prevention, care, and treatment as defined in the FOA?

B. Review of Relevant Information

- Has the applicant identified a process to review the existing Comprehensive HIV Prevention Plan, examine the jurisdiction's current Community Services Assessment and conduct additional assessments as necessary to identify opportunities for selection, adjustment, and coordination of interventions and strategies across funding streams to optimize the impact of HIV prevention, care, and treatment?
- Have applicants who are State health departments identified a process to focus their assessment (if the relevant jurisdiction does not have a current Community Services Assessment) or additional assessment (if the relevant jurisdiction does have a current Community Services Assessment) on the MSAs or specified Metropolitan Divisions within MSAs that have high AIDS prevalence, as listed in the FOA?
- Has the applicant identified a process to review examine current spending patterns in the jurisdiction and the degree to which resource allocations align with the local HIV epidemiological profile?
- Has the applicant identified a process to review the most recent assessment of current capacity and capacity building needs of the targeted MSA or to undertake a new assessment if a relevant assessment specific to the targeted MSA does not exist?

C. Planning Output

- Has the applicant proposed a planning process with clear, specific steps and a timeline that will result in the development of a draft ECHPP by January 15, 2011, that can be shared with CDC and stakeholders and discussed at the January grantee and a final written plan will be submitted by January 31, 2011?

D. Implementation and Evaluation

- Has the applicant proposed to begin, continue, or scale up implementation of the required interventions and strategies in the ECHPP during the project period?
- Has the applicant assured the reporting of diagnoses of HIV infection as well as reporting of all required HIV related testing information (including CD4 and viral load tests) to state and local HIV surveillance programs?
- Has the applicant agreed to collect monitoring and evaluation data consistent with current CDC data requirements for data reporting related to programmatic activities for all new or expanded implementation of interventions or public health strategies as part of this funding announcement?
- Has the applicant agreed to collaborate with the evaluation team identified by CDC and tasked with additional evaluation of grantees' overall programmatic implementation of the ECHPP?

E. Personnel

- Is the proposed staffing plan appropriate and sufficient to accomplish the program goals? Are the staff roles clearly defined?
- Has the applicant agreed to send two or three key staff to attend quarterly meetings convened by CDC with all grantees, including the meeting to be held in Atlanta in October 2010?

a. Has the applicant made plans to ensure that staff has adequate training to implement all interventions and strategies included in the grantee's ECHPP.

F. Budget

- Is the budget for the proposed program reasonable, clearly justified, consistent with the demonstrated need and proposed activities, and likely to lead to successful planning and implementation?

Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care (for example, treatment of HIV, STDs, viral hepatitis, TB, or TB infection; vaccination against Hepatitis A or B). Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.

- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.
- These funds may not be used to supplant state or local health department funds available for HIV prevention, including HIV screening and testing.

If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov.

The applicant can obtain guidance for completing a detailed justified budget on the CDC Web site, at the following Internet address: http://www.cdc.gov/od/pgo/funding/budgetguide.htm.

APPLICATION REVIEW PROCESS

Intergovernmental Review of Applications

Executive order 12372 does not apply to this program.

Application Review Process

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) staff and for responsiveness jointly by Division of HIV/AIDS Prevention

(DHAP), NCHHSTP and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified the application did not meet submission requirements.

CDC will conduct a Technical Review to evaluate complete and responsive applications according to the criteria listed in Section V. Application and Submission Information, subsection "Evaluation Criteria." Applicants will be notified if their application did not meet program requirements.

APPLICATION SELECTION PROCESS

All eligible and technically acceptable applications will be funded.

VII. AWARD ADMINISTRATION INFORMATION

Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and emailed to the program director and a hard copy mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to this project:

- AR - 4 HIV/AIDS Confidentiality Provisions.
- AR - 5 HIV Program Review Panel Requirements.
- AR - 7 Executive Order 12372 Review.
- AR - 8 Public Health System Reporting Requirements.
- AR - 9 Paperwork Reduction Act Requirements.
- AR - 10 Smoke-Free Workplace Requirements.
- AR - 11 Healthy People 2010.
- AR - 12 Lobbying Restrictions.
- AR - 14 Accounting System Requirements.
- AR - 15 Proof of Non-profit Status.
- AR - 16 Security Clearance Requirement.
- AR - 20 Conference Support.
- AR - 21 Small, Minority, And Women-owned Business.
- AR - 23 Compliance with 45 C.F.R. Part 87.
- AR - 24 Health Insurance Portability and Accountability Act Requirements.
- AR - 25 Release and Sharing of Data.
- AR - 27 Conference Disclaimer and Use of Logos.
- AR-29 Federal Leadership on Reducing Text Messaging While Driving

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm .

For more information on the Code of Federal Regulations, see the National Archives and Records Administration, at the following Internet address: http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

TERMS AND CONDITIONS

Reporting Requirements

The applicant must provide CDC with an original, plus two hard copies, of its final performance and Financial Status (SF 269) reports, both of which are due no more than 90 days after the end of the project period. Additional guidance on what to include in the final performance report will be provided by CDC approximately 3 months prior to the end of the budget period.

These reports must be submitted to the attention of the Grants Management Specialist listed in the "VII. Agency Contacts" section of this announcement.

VIII. AGENCY CONTACTS

CDC encourages inquiries concerning this announcement.

For **program technical assistance**, contact:

David Purcell, Project Officer

Department of Health and Human Services

Centers for Disease Control and Prevention

Division of HIV/AIDS Prevention, Office of the Director

1600 Clifton Rd., MS E-37

Atlanta, GA 30333

Telephone: 4046391934

Email: DPurcell@cdc.gov

For **financial, grants management, or budget assistance**, contact:

Patricia French, Grants Management Specialist

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-15

Atlanta, GA 30341

Telephone: 770.488.2849

Email: PFrench@cdc.gov

For assistance with **submission difficulties (also see pages 40-41)**, contact:

Grants.gov Contact Center Phone: 1-800-518-4726

Hours of Operation: 24 hours a day, 7 days a week. Closed on federal holidays.

For **application submission questions**, contact:

Technical Information Management Section

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2700

E-mail: pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at: TTY 1-888-232-6348.

Other Information

Other CDC funding opportunity announcements can be found at www.grants.gov.